FINAL REPORT

COMMUNITY HEALTH WORKER PROJECT

June, 1974

Esther Wattenberg, Coordinator
Elaine Hutton, Director
Sally Flax, Counselor

FINAL REPORT

COMMUNITY HEALTH WORKER PROJECT
June 1974

Esther Wattenberg, Coordinator

Elaine Hutton, Director

Sally Flax, Counselor

ACKNOWLEDGEMENTS

Good-bye, good-bye, we had such a good time with this small experimental program... that really worked! Never again will I wonder if an institution such as the University can respond to the needs of the non-traditional student. Never again will we be hesitant about approaching the community for input and support. Never again will we assume that departments are rigid and unyielding (they're just expensive to negotiate with).

We found that a program such as this does not operate in a void - the staff at the bookstore, the people in admissions and records, the clerical staff in every department we interfaced with, were helpful in so many ways. We can't thank you enough. It's those small things you did, like making a phone call to the office rather than making the students walk over, or looking carefully at their documents and catching the slip ups, that made our students feel comfortable. We wouldn't have been nearly so successful without you.

To CURA, General College and Public Health, we thank you for making us feel welcome. We always liked explaining to anyone who would listen how we really did belong to all three of you.

Special recognition goes to the Office of Career Development where we were housed. They provided us with the benefit of their expertise that was gathered doing special programs like these. Without their direction and intervention we would not have accomplished so much in so short a time. A lot of personal growth takes place in a program like this, and the students and I have certainly grown together. Where ever each of us goes from this place, we will always have warm and fond memories for this special place within the University. The Community Health Worker Project staff and students say again to you all, thank you for this, a first step upon a long, fruitful journey.

Warm Personal Regards,

Elaine Hutton, Director

TABLE OF CONTENTS

SPECIAL FEATURES OF THE COMMUNITY HEALTH WORKER PROJECT

1. Curriculum development that had input from the community residents, staffs of the neighbourhood health centers, participants in the project, University faculty, and special consultants in a variety of fields.

2. A refinement of the work-study model whereby participants attended day school with a minimum of 12 credits and had their practicum in the health centers on an ongoing basis for additional college credit. A maximum number of field work credits for the AA degree is fifteen.

3. A supervised practicum that included cooperation from the faculty of the University and professionals in the neighbourhood health centers. Students were responsible for drawing up a contract which stated their goals for each quarter and a journal of hours spent in direct patient service. This document was certified by the staff of the neighbourhood health centers and a staff member of the project.

4. Transferability of credits between the community colleges, the vocational-technical systems and the General College of the University of Minnesota.

5. The Laddering of health careers from the AA level to the professional level.

6. The selection of participants reflects the ethnic minorities that are strikingly underrepresented in the health professions in this community.

7. The financial linkages that included Hennepin and Ramsey County WIN programs, Career Opportunities Program, New Careers and Regents Scholarship monies.

8. The community linkages that have been established and maintained with this project.

June, 1974

FINAL REPORT OF THE COMMUNITY HEALTH WORKER PROJECT

Office of Career Development
University of Minnesota

Elaine Hutton, Director

The Community Health Worker Project at the University of Minnesota was jointly sponsored by the School of Public Health and the Center for Urban and Regional Affairs. Its curriculum and accreditation were housed in the General College which is known for its innovative and experimental nature.

THE DEFINITION

A community health worker has been known in the past in less than specific terms. The "bridge person", the "outreach worker", the "indigenous worker", etc. Our experience expands these former definitions: "A community health worker is a person who possesses a certifiable health career skill, a broad social work perspective, an intimate knowledge of health systems coupled with the ability to enable these systems to become more responsive, and an advocacy point of view."

We break with the traditional definitions in one major area, the inclusion of a health career skill. Experience here in the Twin Cities area and a search of the literature indicates that the broad generic skills that are provided the community health worker limit her employment to those agencies or institutions that usually are the recipients of the federal dollar. When that dollar is gone, so is the position of that worker. These general skills are not valued highly in the open market. By enabling the worker to also receive training in specific technical areas such as RN, LPN, Lab Tech, OTA, PTA, medical records assistant, etc., we feel ongoing employment is no longer at the mercy of either the federal dollars or a particular agency's ability to employ outreach staff for a particualr year.

We view this inclusive definition as essential in bringing disadvantaged and minority people into the current health delivery system.

THE BEGINNING

This project began as a response to people who were hired as aides, assistants and workers in the health arena. An initial survey[1] indicated they were dissatisfied with their titles, their duties, and their perceptions of how they were perceived by the staff they interacted with and the patients they provided service for. At that same time a new component of the health delivery system was just emerging--the neighborhood clinic known variously as community controlled clinics and free clinics. Since this component was entirely staffed by volunteers we attempted to respond to them also. Concurrently, ex-medics were returning from Viet Nam with no viable means of entering the health delivery system; and the infamous Talmadge Amendment[2] was made the law of the land, turning many AFDC mothers into the already saturated labor market without skills or training. All of these events presented us the opportunity to work with four diverse groups.

It was interesting to note the health agency people were the last to respond to the recruitment efforts. Released time from their job responsibilities was sited as one problem and the lack of a career laddering practice as the other. People were unwilling to start upon the rigorous pursuit of academic training and technical training without some assurance that there would be promotions or salary increases. In an attempt to recruit health aides from a local agency a conversation remains very clear in my mind. Our efforts were centered about a thirty-four year old woman who had been a practical nurse in California. She was an extremely capable person with strong leadership qualities in the local community. She was anxious to complete an LPN course at a local vocational high school. After conversations with her supervisor and the civil service representative, she came to our office and said she would not be entering our program because

---

[1]Systems Development Project, Vernon Weckworth. "Attitudes, duties and titles of community health workers".

[2]Public Law 92-223 enacted July 1, 1972. Also known as the Talmadge Amendment.

she would still just be a Health Aide when she completed the program and would be overqualified for that. She had been with the city for four years and had built up a pretty good pension fund and as long as the city wouldn't promote her for gaining skills she concluded with a sense of resignation they could just take care of her till she retired. Released time became another barrier to recruiting from local agencies. When one of our first courses was scheduled for four days per week agencies began to worry about who would cover the clinics and who would make the home visits. These same agencies had been more than eager to participate while we were in the planning stages, and all endorsed the concept of further training for their workers. They also endorsed the concept of released time but we do not think they anticipated the percentage of respondents. If released time is as valuable a method as we think, we ought to reimburse agencies for it.

By the end of the planning phase of the program which included our major recruitment efforts during the first three months, our statistics revealed participation from these groups:

Agency or institutional people. . . 0
Neighborhood Health People. 9
Ex-medics 3
AFDC or WIN women 4

At the end of the first year when recruitment was completed our student population reflected these numbers and demographic characteristics:*

Agency or institutional people. . . 9
Neighborhood Health People. 16
Ex-medics 3
AFDC or WIN women 4

Males 9
Females 23

Black 12
Caucasian 16
Chicano 2
Indian. 2

Age Range: 19-52

*See appendix for full demographic information on all of the students from the 2 years.

THE FINANCIAL PICTURE

Given the size of the award from Health Manpower Development Program for our small experimental project of 20 students, we were underfinanced for the ever expanding numbers of people who viewed the Community Health Worker concept as vital to their career development and our financial headaches were immediate and critical.

Our first act was to approach the Board of Regents for additional monies for our agency people. We were successful and secured training monies for approximately ten students. The only restriction was that this money was earmarked for University tuition and could not be spent at cooperating institutions that were providing technical training for our students. The WIN programs of both local county welfare departments were anxious for their women who had evidenced an interest in health careers to participate in this program but were unable in some instances to provide any educational funds. At the time of the Talmadge ammendment, men were the primary target groups for training. They did agree to supply transportation and babysitting monies for their clients. By establishing a liaison with Operation Medhic we were able to use the GI bill for our ex-medics. By approaching the BIA, we were able to secure further transportation and babysitting monies for our Native Americans. Our other two groups were supplied tuition, fees and books out of our award. With this rather interesting intermingling of funding sources we were able to circumvent a potential financial disaster. If indeed a program such as this is to survive, pooling of the financial resources of the community is essential.

We would like to reiterate one major point. Tuition and books are a critical part of the success of a program such as this, the tight money market, notwithstanding. To give the nontraditional student any less is to ensure that the

system will place unmoveable roadblocks in their way. Looking back over the past two years, we find that we are far more involved with the students who were supported by the program than those who were not. During the entire second year we could not accept anyone who did not have means of paying their own tuition. When this project was negotiating for slots at other institutions, we found that we could reserve more slots if they could bill us direct. We would not go so far as to say that our students received preferential treatment but we were always notified promptly if our students were having personal or academic difficulty. With the close relationships with the participants and the faculties of the cooperating institutions we were able to interceed at appropriate levels. If our students were doing exceptionally well or were cited for special recognition, we were alerted about that too.

FINANCIAL LINKAGES

Our funding sources in the second year were many. We received most of our contributions in staff time, tuition at cooperating institutions at a reduced rate, and Regent's scholarship monies. At St. Mary's Junior College the tuition is $1500.00 per year, we have four students currently enrolled. St. Mary's contribution is $3,072.00. That is exactly one half of what we would be paying for four full time students. The Ramsey County WIN program is sponsoring the complete financial package for an occupational therapy program for one of our participants. We currently have one student supported by New Careers and one students supported by the Career Opportunities program which is lodged in the public school system in the city of Minneapolis. These financial linkages indicate the amount of commitment to this program from the sources it interacts with. Our Regent's monies support the tuition package for eight students who are currently enrolled here at the University.

SUPPORT SYSTEMS

Career Choices: Academic Counseling. In counseling participants for the second year of the program, we have found that many of our participants have enlarged their career choices. Graduate school has become a viable option for four of our students and they have been accepted into the Health Education Department and the Public Health Administration in the School of Public Health. Not one of these participants had graduate school in mind when they entered the program. With college credit being given for their field experience, many students seemed unaware of how quickly they were amassing credits. By the time many had received their AA degree they had a substantial number of credits toward their Bachelor's degree. With the quixotic nature of the neighborhood health centers and the emergence of HMO's as a viable method of delivering health care, more training was desirable for our participants in order that they might be more competitive with the more highly trained professional. If the program had to rest on any one achievement, it would be that disadvantaged and minority people can move rapidly along the educational ladder, just as rapdily as the traditional student, given the opportunity and support systems supplied by a program such as this.

Curriculum. The curriculum that was designed exclusively for this project in its first year set the tone for the camaraderie and joint goal making for its participants. That is crucial when working with the non-traditional student. The courses that were all designed within the context of the neighborhood health centers served to help define what it was the student already knew. It gave the students an opportunity to participate in class discussions, learn the rudimentary skills needed to do interviewing and surveying, exposed them to resources for learning that previously were unknown to them, and gave them the opportunity to work with college professors and college work on a very personal basis. Even now,

more than a year after most of the students are no longer taking closed classes, they still maintain strong ties with these professors. For a brief description of the classes that were designed for the community health worker students, see attachment 1.

Tutoring. Tutoring is available to all of our students through the HELP Center. We have found a lesser need for tutoring in the second year of the program than in the first year of the program. During the summer of 1973 we arranged with the Institute of Technology to provide a chemistry tutor for those of our participants who were entering their professional schools in the fall of 1974. Not one of the participating students has had any difficulty with chemistry this year.

The Study Skills center here at the University has also been extremely valuable in aptitude testing and preparing those students who needed it for the GED. The student groups within the program also act as informal tutoring groups. The students share textbooks, notes and ideas with each other. Having this camaraderie within the group is valuable and we feel it has lessened our attrition rate considerably. Tutoring has to be an ongoing service of a program such as this.

COMMUNITY LIAISONS

The Community Health Worker Project has many valuable liaisons in the community. We have used these liaisons extensively for recruitment, consultation and a political base for organizing. They include Hennepin County Health Coalition, Metropolitan Council, Metropolitan Medical Complex, Community Health Incorporated, Northeast Community Organization and all of our various neighborhood health centers.

The staff of this program spoke to four inner city University extension classes about the concept of the emerging community health worker. The total audience was 126 people of which 112 were Black or Indian. We had forty serious

inquiries but without being able to offer funding, we could only refer them to other sources of financial aid. Whereas this may sound feasible it is not viable. All of these forty-four potential applicants were over the age of thirty-five and had been out of school for a number of years. Without exception they were working in nursing homes as aides and orderlies or other low skill jobs and most wished only to move up to the LPN scale or at the most the RN. These programs are available in the Voc-tech system for a nominal fee, but, not one of these applicants is currently enrolled. What this program could have offered, if it could have afforded to, was an advocate to reserve spots in these institutions. It could have provided a focal point where all of these individuals could have come together with their common goals. The non-traditional student needs much more reassurance than the traditional student.

Many of this group have been referred to the Mature Women's clinic, a community based agency that has as its charge, finding ways to enable women to reenter the job market. It is our hope that this clinic will be able to build the ego strengths of these women and assume the role of advocate with the training institutions.

Given the rapidly changing face of the health delivery system, this project has been timely indeed. Since our inception issues have come to the attention of the public that were in the area of our domain, decentralized health care, primary health care, the advent of Health Maintenance Organizations, and the role of the University's Health Sciences complex in the delivery of health care. We were in no position to be the experts on all of these issues but we were in the position to have input and to observe and interact with all of the participants. We all learned, the staff as well as the students. The learning we all did in the community was just as valid and relevant as the learning that took place in the classroom and the clinic.

THE STUDENT POPULATION

Participants in the Community Health Worker Program

Recruitment Sources--where they came from:

Neighborhood Health Centers	10
Operation Medhic	4
Hennepin County WIN	4
Ramsey County WIN	3
Public Service Careers	2
Dental School	1
Anoka County WIN	1
Opportunities in Health for Minorities	2
General College	7
U of M Faculty	1
Source Unknown	7

The student population of this project was consistently maintained at a 50% racial balance. Given the fact that Blacks, Chicanos and Indians make up less than 10% of the total population in the metropolitan area this was no small feat. We account for this in the following ways:

The Office of Career Development has administered many programs that have benefited low income minority groups. It maintains a credibility with the community that allows a trust relationship to continue.

The staff of the program came in large parts from other community programs. The use of special community program assistants allowed us to keep close contacts with the participants.

Our goal was to enable participants to achieve the AA degree and a health skill, this time frame seemed far more manageable to our participants than a four year program. It is interesting to note that as we phase out the program a significant number of our participants will continue to pursue the BAS degree.

Special counseling efforts were initiated at the beginning of the second year. They included personal, financial and goal oriented sessions.

Our students perform many tasks within the clinic structure. We have students who under supervision utilize their new nursing skills. These women have just completed their first year at Metropolitan Community college and St. Mary's Junior college. Another student is performing personal care and counseling to a group of thirty-five mentally and physically handicapped high school students. He is our public health officer in the public school. Another student is responsible

for coordinating services at one of the neighborhood clinics. By far the largest number of our students are advocates within their respective clinics. One of them is in the process of writing a booklet on how to select and train advocates in a community clinic. One of our Indian students is now greeting and scheduling patients at the Community University Health Care Center. This center is the main provider of health care to our Urban Indian population.

One of our Chicano students was recently on television in a human interest story. She is the interpreter for Spanish speaking people at a local hospital.

ACADEMIC ACHIEVEMENT

The twenty-seven current participants in the community health worker project have done well academically. The following chart indicates the grade point averages of these students. This chart reflects grades through winter quarter 1974.

3.5-4.0	4
3.0-3.4	7
2.5-2.9	11
2.0-2.4	4
Below 2..	1

Out of our total population of 42 participants, the breakdown of certificates, diplomas and degrees is as follows:

GED only	1
AA Degree	9
B.A.S..	8
Certificate	1

With the academic achievement of our students their career choices changed between the first and second year:

CAREER CHOICES	Spring 1973	Spring 1974
Physician	0	2
Public Health Administration	0	1
Health Education	1	3
Registered Nurse	5	6
Registered Nurse with a Baccalaureate Degree	1	5
Medical Technologist	0	2
Lab Technician	6	5

	1973	1974
Social Worker	2	2
Teacher	1	2
Occupational Therapy Assistant	1	1
Psychiatric Technician	3	1
Community Health Worker	11	5
Physicians Assistant	3	3
Undecided	8	4
TOTAL	42	42

The students who have been accepted into the Graduate school represent an additional achievement. The BAS degree with the community health emphasis is only two years old and its curriculum had never been used as a criteria for admission to graduate programs. The acceptance of these students reinforces other evidence that the curriculum is valid and relevant, and that it is possible to ladder the non-traditional student all the way to a professional career.

EVALUATION

The evaluation of our graduate student who was assigned to the program is attached (see attachment 2). The self evaluation checklist is also attached (see attachment 3). Our original proposal indicated we would secure an independent evaluation of a medical sociologist, unfortunately our funding did not permit this. We are enclosing an additional copy of the first year's evaluation in order that the changes may be noted (attachment 4).

ATTACHMENT 1

CURRICULUM OUTLINE

A TWO-YEAR PROGRAM LEADING TO AN AA: Community Health Worker

SUMMER PROGRAM

I. Orientation

1. The Community Health Worker Project

2. The University and what it offers

3. Intensive Counseling--health career options

II. Understanding the neighborhood and its health needs

Five credit seminar - Public Health No. 5-098

III. Developing the Drug and Community Resources Manual

IV. Some basic patient care skills

PROGRAM BEGINNING FALL, 1972

I. Health Career Credits 45

(LPN, RN, X-ray Technician, Lab Technican, etc.)

Core Requirements . . . . . up to 25 credits

1. The Helping Process and the Neighborhood Health Worker
(an understanding of the advocacy role)

2. Communications
Report writing
Small group interaction
Interviewing
Fundamentals of medical terminology
Principles of communication oral, written, non-verbal

3. Issues in Community Health (up to 15 credits) - P.H.
Issues in Health Care and the Community
Concepts of Health Maintenance--How the Health System works
The Community and its Resources

OPTIONAL

4. Survey Techniques

Introduction to Data Processing

II. Career Related Coursework - up to 10 Credits

Soc. Sci. 1-984 - An Introduction to Community Development

Psy 1-003 - Psychology of Human Development

or

GC 1-283 - Application of Psychology to living

GC 1-211 - Man in Society: the Urban Crisis

GC 1-731 - Consumer Problems (Economics)

GC 1-481 - Creative Problem Solving

ELECTIVES 10 credits some suggestions

Possible Business Studies

1. Management and Supervision - (under development in Business Studies)
2. GC 1-285 - Cultural Anthropology
3. GC 1-295 - Economic Perspectives
4. GC 1-233 - American Government and Politics

ATTACHMENT 2

June, 1974

EVALUATION
Community Health Worker Project

Office of Career Development
University of Minnesota

The program objective as stated in the Community Health Worker Interim Progress Report, Spring 1973, was to develop and demonstrate a model work/study program for community health workers in neighborhood health facilities by means of the following features:

1. An interdisciplinary curriculum to encompass both patient care skills and patient advocacy, to fill the pressing need of health center staff for comprehensive training to meet in more responsive ways the community's health care needs.

2. An integrated work/study program with credits for field work experience, to advance the students toward a recognized credential in a health career, from a 45 credit certificate to an AA degree, and beyond.

3. The use of the program as a vehicle for effecting joint communication and program effots among professional health center staff and residents, among separate neighborhood health centers, and between various health centers and University resources.

It was documented in a July 1973 Evaluation that the skill levels of the students had increased during the first 9 months of the Community Health Worker Project. In this final evaluation an attempt was made to determine if increased levels of skills among Community Health Workers had enabled them to meet in more responsive ways the community's health care needs.

To ascertain whether the first objective had been met, it was necessary to contact either the clinic directors or the immediate supervisors of the students enrolled in the program. The following questions were asked:

1. How many people have used the clinic as a result of the efforts of the Community Health Worker (CHW)?

2. Has there been an increase in patient visits since the CHW has received some training?

3. Has there been a difference in attendance, quality of care, or effective utilization of service as a result of the efforts of the CHW?

4. Do you have any information to prove that the CHW Project is useful and should be continued?

With the exception of the Pediatric Clinic at General Hospital, none of the clinics collected data which would answer the above questions. Some clinic assignments of students were made in conjunction with the Community Health Worker Project; hence, there could be no before and after data concerning the effectiveness of the students. However, the CHW in the Pediatric Clinic at General Hospital had been on his job as an outreach person for 8 months before enrolling in the Community Health Worker Project. His supervisor at General Hospital stated that even though the CHW had been give on-the-job training, he still seemed frustrated by his job until after he had enrolled in the Project. (This was the second outreach worker employed by the clinic. The first had become frustrated and quit after 1 year.) The project, according to the supervisor, gave the CHW more direction and insight into his job. The CHW demonstrated initiative--which had been lacking previously--by starting on his own to develop a Home Assessment Form.

Further, the supervisor noted that the fail rate of the clinic had dropped from 60% to 15% as a result of the CHW's efforts; there was a marked increase in the number of patients calling to talk to the CHW, and an increase in the number of referrals to the CHW from professionals on the staff. Thus, one supervisor of a CHW could state without reservation that there had been a "definite improvement in the quality of care" as a result of the Community Health Worker Project.

In a second example of a CHW who had been functioning in that capacity before enrolling in the project, the worker herself states that before enrolling in the project she was "just a sympathetic housewife," but after training she had more confidence in what was needed and expected as a CHW and felt more skillful. Although her clinic did not collect data to substantiate whether or not her feelings were translated into actions, her promotion from patient advocate to Clinic Coordinator would indicate her skill attainment.

Adequate evaluation of the first objective is made even more difficult by the job mobility that occurs as students advance toward and receive recognized credentials in a health career. It would be necessary to follow the students' progress in their new health careers to adequately assess the affect of this project in preparing the worker to better meet the health care needs of the community. Yet, the fact that 19 out of 42 participants received either a certificate, an AA, or a bachelor's degree indicates the effectiveness of this project in meeting the second objective.

From a representative sample of students who have gotten degrees through this project, 2 out of 5 had "no intentions" of ever going back to school; 3 out of 5 wanted to go back to school, but did not think it would be possible financially. One student stated that he also needed "direction," which he admits he got through the Community Health Worker Project. Thus, the Community Health Worker Project has been successful, as stated in the July 1973 Evaluation, in facilitating the attainment of additional schooling by the participants.

STATUS OF THE STUDENTS AT THE END OF THE PROJECT

Total Number of students who enrolled in Project	42
Drop-outs	12
GED (only)	1
AA degree	9
Bachelor's degree	8
Completed Certificate Program (45 credits)	1
Those in pursuit of varying credentials	11

IMPLICATIONS FOR THE FUTURE

The lack of sufficient data to document whether or not this project had an impact on increasing quantity and improving quality of health care services in neighborhood health centers is not indicative of failure to meet this objective.

It is more indicative of inadequate communication in the early planning stages between the project staff and the staffs of the various clinics. Clinic directors or CHW supervisors have to be aware that they have a role to play in such a project. In future projects of this type the coopeartion of the clinic staffs will have to be solicited and gained in order to evaluate the affect of the project on the clinic's delivery of health care. Gaining the cooperation of clinic staffs is no easy task, because even though the clinic personnel may agree with the objectives of the project, the clinics are often understaffed and overburdened and simply do not have the time or manpower to collect the necessary data.

It is significant to note that the one clinic which did collect data was the one that was part of a larger organization. The supervisor at this clinic expressed the fact that she was acutely aware of the importance of evaluations and of having to "justify" her actions. The responses of the personnel of the smaller, free standing clinics indicate that they do not put the same emphasis on evaluations. It is in the area of evaluation that the staffs of future projects of this type may have to devote a great amount of energy to ensure the understanding and cooperation of the staffs of participating clinics. Yet, one has to be aware of the nature of the neighborhood free clinic at the time this project began. The free clinic concept was still in its infancy and the clinics were staffed mainly by volunteers who were disdainful of the establishment way of doing things. It is to some extent unrealistic to expect to use "establishment" standards to measure the effects of an "establishment" project on the delivery of community health care by somewhat anti-establishment clinics.

ATTACHMENT 3

Please answer the following questions and give them back to me:

What is your health career goal at this point?

What have you done to achieve your health career goal (made application, have it already, nothing, etc.)?

What can I do to help you achieve your goal?

What is the community clinic you are involved in?

If you are not involved in a clinic what kind of community effort are you involved in?

If you are not involved in either of the above when can I expect to see involvement and how can I help?

Those of you who are involved in the community or community clinic when can I expect to see your contracts (If you don't know what a contract is--see me!)?

ATTACHMENT 4

EVALUATION

Community Health Worker Project
Office of Career Development
University of Minnesota
July, 1973

Introduction

Throughout the Minneapolis-St. Paul area there has been a movement to provide health care in community centers. Despite efforts in this direction there is growing evidence that health care is not reaching specific groups in the community such as the poor and racial minorities. In order to change this situation community health centers are increasingly using community residents on their staffs whenever possible.

The quality of training of these community residents varies greatly. Each health center provides its own orientation or on-the-job training. The title, role, and expected areas of competance of the community health worker varies from agency to agency, making it difficult to integrate the worker into the health team. This lack of a standard quality education for community health workers both lessens the quality of care they have to offer and minimizes the career mobility open to them.

The Community Health Worker Program which is run through the Office of Career Development at the University of Minnesota has attacked both of these problems. It has attempted to provide neighborhood staff of community health centers with the background and skills necessary for them to offer both patient care and client advocacy competencies and to ensure that its curriculum provides access to a range of professional health careers for the community health worker.

Participants in the Community Health Worker Program are mainly minority people with yearly incomes below $3000 (see Appendix I). They work in various community health centers and take time off each day to attend classes at the University of Minnesota. There is a core curriculum developed by the Community Health Worker Program in which all participants are involved. Participants are encouraged to take additional classes which will lead to an AA degree.

Method

The purpose of this evaluation was to determine if the Community Health Worker Program achieved two of its major goals, those of increasing the participants' patient care and client advocacy skills and of increasing the career opportunities open to them. Because of the wide variety of skills used by the community health workers and the nebulous nature of their career opportunities no formal hypotheses were formed. Instead this evaluation was aimed at getting a general picture of the effect of the Community Health Worker Program on the participants.

There were 33 community health workers who participated in the program. A questionnaire was mailed to each of the twenty five community health workers who were in the program at the time. Fifteen of the community health workers replied. The participants were asked to rate their own skills in fourteen areas on two five point scales. One scale measured where they stood before entering the program and once scale represented where they stood after completing nine months in the program. A supervisor in each participant health center also rated the participants on similar scales. The five point scales which measured the fourteen different skills needed by community health workers were composed as follows:

1. Beginning to learn designated skills
2.
3. Becoming competent in designated skills
4.
5. Shows expertise in designated skills

The degree to which the participants' skills increased would indicate the degree of success of the program. In the second part of the questionnaire for the participants a number of forced choice questions and open ended questions were aimed at giving a quantitative and qualitative view of the program's effect on the career opportunities of the participants.

Results

The average rating of the participants' skills before entering the program was 2.5. Their average score after nine months in the program was 4.1. The average score of the participants' skills as rated by their supervisors was 2.7 before entering the program and 4.4 after being in the program nine months. In each of the fourteen skills the participants increased from 1.5 to 2 points on the scales.

The part of the questionnaire dealing with career opportunities showed that the program affected the career goals of thirteen of the fifteen responding participants. All the participants stated that the program affected the means needed to reach their goals. Typical comments were the following:

> It [the program] has given me incentive to accomplish a four year degree. It has given me a chance to see if I really wanted a health related career.
>
> It helped me to a large degree to get me started and find out if it's what I really wanted and it is.
>
> It inspired me once again and made it possible to start schooling towards a field I am interested in.

Since beginning the program five of the participants bettered their position at the community health center where they work and three of these five stated that the program caused this change.

All the responding participants stated that the program raised their opinion of themselves as community health workers. Two rather typical comments were the following:

> I am capable of much more than I thought I was--I have developed more self confidence.
>
> I have more confidence in my own expertise and ability to assert myself and I have learned much about human nature and the organizational structures in my community.

All the responding participants stated that the program had a positive effect on them as people. Seven of the fifteen specifically mentioned gaining more self-esteem while in the program. Two typical comments were the following:

Enabled me to continue my education, become an active person in my community and make definite career plans.

I'm not "negative" about everything in life--I've a future to look forward to--changes to make and appreciate both good and bad.

Discussion

The Community Health Worker Program attempted to provide the neighborhood staff of community health centers with skills necessary to offer patient care and client advocacy eompetencies and to provide access to a range of professional health careers. Not only were these goals high and difficult to achieve but they were difficult to measure. Most program evaluations deal with the participant's satisfaction with the program. This evaluation dealt with the change in the participants actual on-the-job skills and with the change in his career opportunities. In order to do this both quantitative and qualitative measures were used.

The Community Health Worker Program was successful in increasing the participating community health workers skills. In fourteen basic skills ranging from communication and client advocacy skills to the ability to identify organizational structures, the participants showed considerable increase during the nine months of the program. They moved from becoming competent in the designated skills to showing expertise in the designated skills. This movement was from 2.5 to 4.1 on a five point scale. This increase in skill was strongly verified by the participants' supervisors in their health centers who rated them as moving from 2.7 to 4.4 on the same five point scales. The great similarity between the participants' assessment of their skills and the supervisors' assessment of the participants' skills indicated that there was a real and noticable increase in the participants skills during the nine month period the participants were in the program.

This close similarity in the assessment of the participants skills also tended to offset two weakness of this evaluation, the lack of a control group and the lack of before and after testing.

It was impossible to obtain a true measurement of the program's effect on the participants' career opportunities. Only time will tell. At the time the program was evaluated three participants said that they bettered their position at work because of the program. It would seem that as the participants integrate their new skills and knowledge with what they already possessed, they will be more able to take advantage of opportunities when they arise. Because this is yet to happen this evaluation did not measure it. This is not to say that the goal of increasing career opportunities was not appropriate. On the contrary, too many programs try to change only what can be measured and ignore important areas which are difficult to measure.

Thirteen of the responding fifteen participants said that the program affected their career goals. Many participants stated that through the program they were able to select a certain area in the health care field in which they wanted to specialize. Others had new areas opened up to them which they wanted to explore.

Two effects of the Community Health Worker Program which were clearly shown by this evaluation were its increasing of the participants' means of achieving their goals and its increasing of the participants' self-esteem. All the responding participants said that the program affected their means of achieving

their goals, with all but three saying that without the program they would not have been able to go to school this year. This additional schooling which was desired by the participant and necessary for advancement in the health care field was not possible for them without the program.

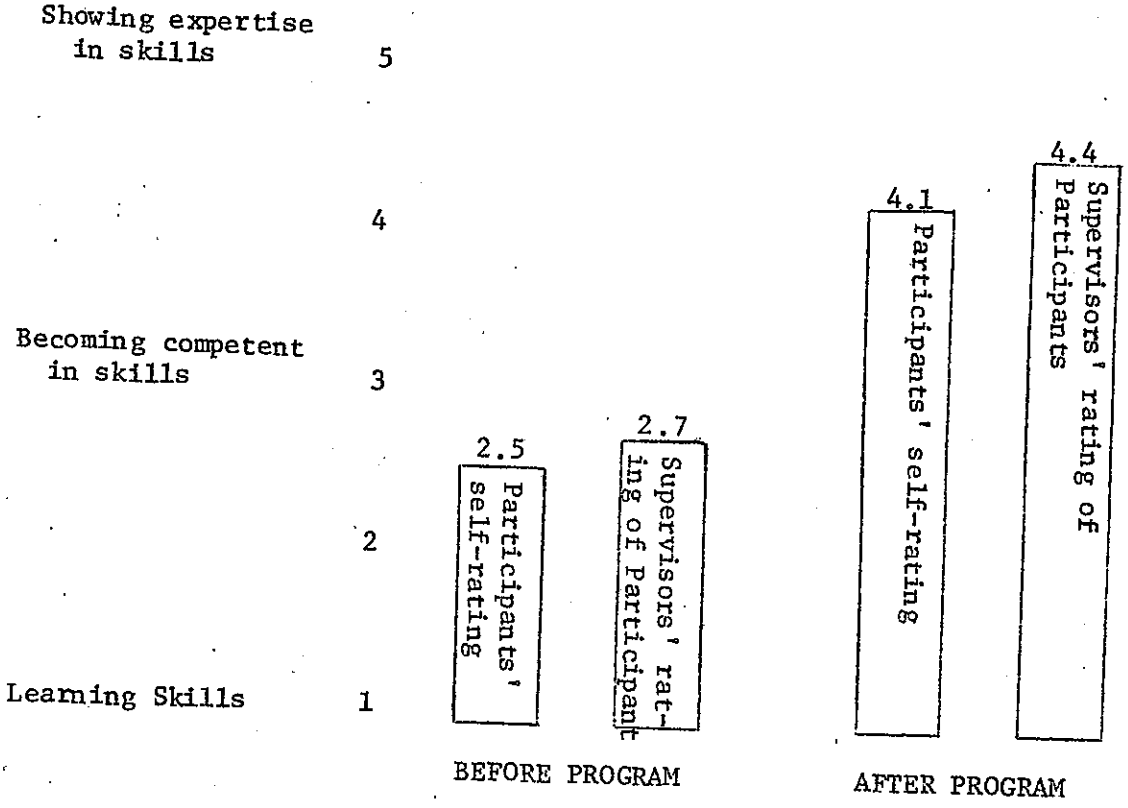
Equally important was the program's effect on the participants' self-esteem. In the midst of taking on new responsibilities in health centers and taking college classes, a new experience for many, all the participants stated that the program had a positive effect on them as community health workers and as people. Of the twelve participants who went on to comment on this, all stated that the program was a good experience and seven specifically stated they gained self-esteem. Thus, the Community Health Worker Program helped the participants gain two important building blocks, schooling and self-esteem, on which increased career opportunities stand.

Conclusion

The Community Health Worker Program attempted to provide neighborhood staff of community health centers with the background and skills necessary for them to offer both patient care and client advocacy competencies and to ensure that its curriculum provided access to a range of professional health careers. The program was successful in both of these goals. The participants rated themselves on their level of skill in fourteen areas. They showed considerable increases in all these areas over the course of the first nine months of the program. The increases in skills were verified by the participants' supervisors in their health centers who also rated the participants.

Although it is too early to tell what effect the program will have on future career opportunities, it has affected the career goals of the participants and the means of achieving these goals. Two important effects of the Community Health Worker Program which became apparent in this evaluation were that it provided desired schooling which was not otherwise available to the participants and it had positive effects on the self-esteem of the participants.

COMPARISON OF SKILL RATINGS



ATTACHMENT 5

Since June of 1972, 79 applicants have applied for admission to the Community Health Worker Project. The following statistics reflect information about the 52 people who are no longer active with the project.

EDUCATIONAL BACKGROUND

8-10 Years of School	11th Grade	12th Grade	1 year or less of college	GED
9	6	25	11	1

ETHNIC GROUP

Black	Chicano	Native American	Caucasian
15	9	10	18

AGE GROUPS

18-20	21-25	26-30	31-35	36-40	Over 40
7	11	14	6	7	7

PROGRAM COMPLETIONS WITH CERTIFICATIONS

BAS	AA	Diploma
3	4	2

TERMINATIONS BEFORE COMPLETION OF PROGRAM

Private employment. 14
Health related employment . . 17
Left geographic area. 1
Unknown 7
Other sources of funding. . . 4